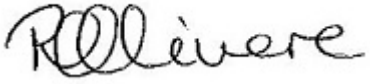
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, Birmingham Community Healthcare NHS Foundation Trust**
1	**CORONER** I am Rebecca Ollivere, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 8 November 2022, I commenced an investigation into the death of Carol Ann CLEMENTS. The investigation concluded at the end of the inquest. The conclusion of the inquest was:- Died as the result of an accident
4	**CIRCUMSTANCES OF THE DEATH** **The deceased was a resident at Perry Trees Centre following discharge from hospital after surgery to repair a hip fracture. Whilst at the centre, she was incorrectly assessed as being a medium risk of falls, when in fact, she should have been categorised as a high risk. She therefore did not have the correct level of supervision. On 2nd October 2022, Carol was found on the floor of her room, having been previously sat in her chair by staff. The fall was unwitnessed. Carol sustained a further hip fracture as a result of this fall. She was returned to hospital where further surgical fixation was carried out successfully. Initially, she recovered well post operatively, however, Carol developed Pneumonia. She had a RESPECT form in place from her earlier admission and therefore her care was comfort care only. Her Pneumonia progressed to Sepsis, and she died on 23rd October 2022 in hospital.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Multiorgan Failure** **1b Sepsis** **1c Pneumonia** **II fixation of peri-prosthetic fracture of femur**
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. - 1. Enhanced Supervision Levels training is not included on mandatory training programmes. Whilst some training sessions have been delivered by the trust to current staff members following this incident, I am concerned that new staff members joining will not be suitably trained in this area.

	2. Falls risk assessment training is on the essential role training programme, however, I am concerned that this area is not covered suitably on induction of staff to the centre. This leaves a gap, particularly with agency staff, and I am not satisfied that with the current processes, agency staff will be fully versed on the completion of these risk assessments. 3. I was told that since this incident, falls risk assessments are being audited for compliance. I was also told that they are not being audited for correctness. I am therefore concerned that errors, and consequently, staff training needs, would not be picked up in these audits.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 July 2023. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action - otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: **University Hospitals Birmingham NHS Trust** **Mrs Clements' family** I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**30 May 2023** Signature:  **Rebecca Ollivere** **Assistant Coroner for Birmingham and Solihull**